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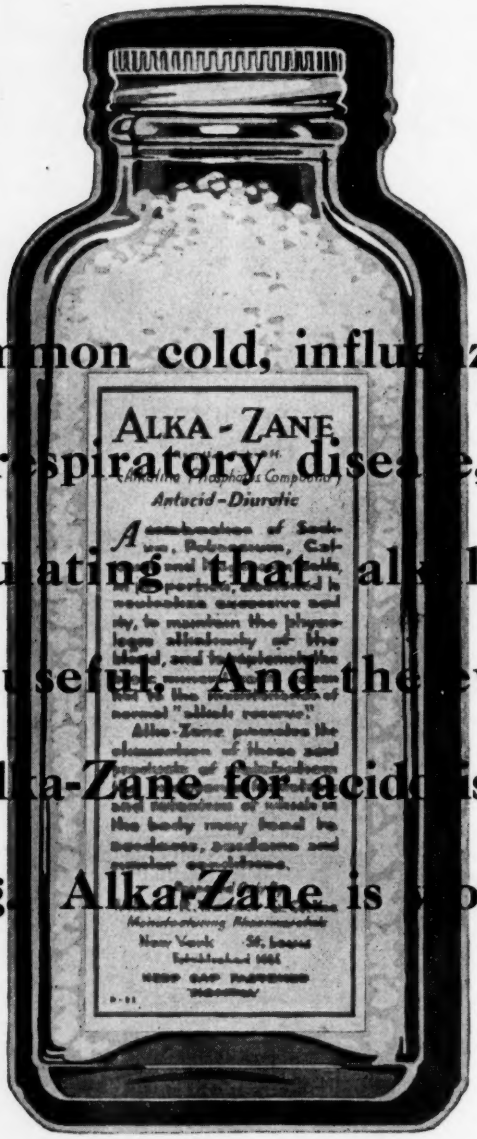

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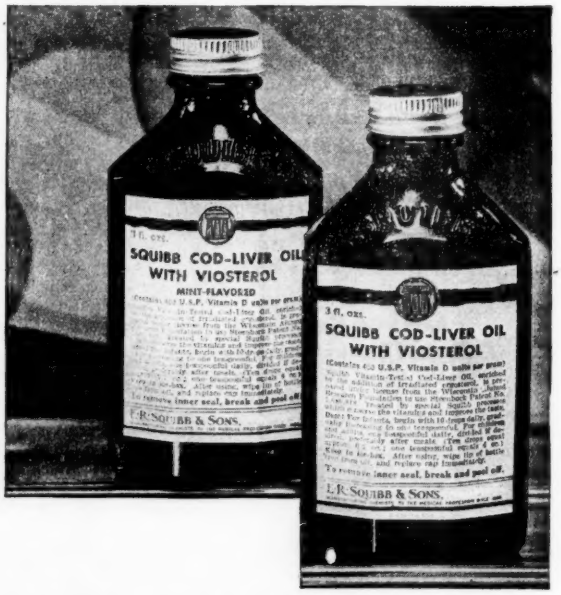

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Clinical Section

The Modern Treatment of Cardiovascular Syphilis

By

W. GEORGE BROCK, B.A., M.D. (Man.), M.S. (Minn.), Winnipeg

Before the advent of arsphenamine as a therapeutic agent, it was accepted that the use of iodides and mercury caused some alleviation of symptoms and actual improvement in cases of cardiovascular syphilis. Arsphenamine having been hailed as the great cure all for syphilis was, against persistent warning, used indiscriminately and frequently in large doses in the treatment of cardiovascular lues. The result was disastrous. Consequently, for many years, no other treatment than ordinary medical care to meet immediate indications of heart failure was attempted. Towards the end of the war it was discovered that the less cardio-toxic neo-arsphenamine could be utilized beneficially in smaller doses. Gradually our modern system of preparation with mercury or bismuth and the iodides, followed by small increasing doses of neo-arsphenamine, and subsequent alternating courses of these drugs, was evolved. Recent statistical studies show a prolongation of life and usefulness in cases of cardiovascular lues which proves the value of the treatment.

To understand the modern conception and rationale of treatment of cardiovascular syphilis, it is necessary to have a working knowledge first of the pathology of the disease, and second of the effect of the anti-syphilitic drugs upon the morbid process.

Pathology.

Essentially, cardiovascular syphilis means syphilis of the aorta[1]. In 1918 Klotz drew attention to the fact that he had noticed at necropsy the frequent involvement of the lymphatics leading from the aorta to the mediastinal glands, and drew attention to the existence of a mediastinitis. The theory has been evolved and gained general acceptance, that, following the spirochætemia present in the early phase of syphilitic infection, the spirachaetes are filtered out in the lungs (Martland), reach the mediastinal glands and, during the latent period, invade the lymphatics of the mediastinum. Because these lymphatics are richly distributed about the first two or three inches of the ascending aorta, a peri-aortitis is produced, the adventitia becoming invaded by the distinctive cellular infiltration. Thence, the inflammatory process spreads into the media along the vasa-vasorum, resulting in endarteritis of these vessels, and spread of the cellular infiltration between the layers of elastica. Progression results in rupture of elastic laminae, weakening of the aortic wall and aneurysmal dilatation (only partially counteracted by thickening of the intima). The infiltration extends towards the heart as far as the mouths of the coronary arteries in the sinuses of Valsalva, producing coronary stenosis which may lead to patches of replacement fibrosis in the myocardium from ischemia. The result of the arrest at this point of the cellular infiltration is an aggregation of cells in the commissures from which the semilunar cusps of the aortic valves spring. The cusps become stiffened, and tethered at their commissural ends. From loss of endothelium from their surfaces, they may become adherent to the aortic intima or to each other. If edematous, they may rupture. In any case, aortic regurgitation results.

Choice of Drugs for Treatment.

Now, to return to the drugs, arsphenamine (606) has a peculiar toxicity for the syphilitic heart. Reid and others have shown by electrocardiographic studies that it increases the conduction time and decreases the refractory phase to such an extent that ectopic ventricular tachycardia and ventricular fibrillation supervene. This is the cause of "arsphenamine collapse" (sudden death). It occurs during administration of the drug.

The second great difficulty with old arsphenamine, "therapeutic shock," resulted in death within 24 to 48 hours following the treatment from the Jarisch Herxheimer reaction. The infiltrated wall of an aneurysm strained to the limit by the sudden edematous swelling, would rupture, or the stenosed mouths of coronary vessels, becoming swollen, shut off the supply of blood to the myocardium.

Lastly, therapeutic paradox blackened the reputation of arsphenamine therapy completely. Under treatment with this drug a simple aortitis rapidly developed into aortic regurgitation or aneurysm. The infiltrate in an aneurysmal wall melted quickly and the sac rapidly became larger. A slight degree of regurgitation became rapidly exaggerated. The myocardium for no apparent reason would fail suddenly, and a formerly well compensated patient die of congestive heart failure. Therapeutic paradox is attributed to too rapid healing of syphilitic inflammatory tissue which is replaced by contractng scar tissue.

Since old arsphenamine gave such bad results, why should neo-arsphenamine be used? It is true that to start treatment with neo-arsphenamine in ordinary doses would invite disaster. But there are several reasons why neo-arsphenamine is used in the modern treatment of cardiovascular lues. First, it is a less toxic drug in syphilitic cardiacs than arsphenamine and yet maintains a high therapeutic index. Secondly, the experience gained from the old 606 taught the wisdom of

small graduated dosage to avoid toxic reactions. Finally, preparatory treatment with mercury or bismuth and the iodides has done much to remove the bugbear of the Jarisch Herxheimer reaction and the therapeutic paradox, and rendered the subsequent use of neo-arsphenamine reasonably safe.

The iodides are supposed to have a solvent action on syphilitic infiltrations (by actual physical test). Mercury is used (in water soluble preparations) because it is a proven anti-syphilitic drug which acts slowly and produces only gradual change. Bismuth, though more potent, is used in insoluble preparations, and slower absorption counteracts any tendency to reaction.

Outline of Treatment.

There are many systems of therapy, but the principle is the same in each. The one used by Moore, Danglade and Reisinger[2] is very practical. Intramuscular injection of 0.1 grammes of an insoluble bismuth salt is given every four or five days for five injections. Then 0.2 grammes are given once a week, if no upset has occurred. In preference to bismuth, Stokes[4] likes to use soluble mercury succinimide gr. ⅙ to ¼ three to four times per week. These injections are continued for ten to twelve weeks, during which time the patient is receiving from 1.3 to 4.0 grammes of potassium or sodium iodide by mouth three times daily. At the end of this course, the cardiac reserve being good, intravenous neo-arsphenamine is given cautiously, the first dose being 0.05 to 0.1 grammes, and gradually increased at weekly intervals to 0.3 grammes. To avoid reactions even of gastro-intestinal type, this dosage is rarely exceeded. Ten to twelve injections are given and then alternating courses of bismuth and neo-arsphenamine are continued for two years at least with, if possible, a repetition of one course of bismuth and neo-arsphenamine each subsequent year.

In case of congestive heart failure, the patient should be put to bed on limited food and fluid intake. He should be digitalized. In the absence of oedema, iodides can be prescribed. In the presence of oedema, salyrgan intravenously, or mercury succinimide (water soluble) intramuscularly, may be given for several days for the combined diuretic and anti-syphilitic effects. The patient should be kept in bed for a reasonable time following the restoration of compensation. Return to activity should be carefully graduated. Patients with a low cardiac reserve may require from 0.1 to 0.2 grammes daily of powdered digitalis over long periods, when ambulant.

Anti-syphilitic treatment in these cases is carried out as prescribed above if compensation is completely restored. If compensation is never completely restored, then neo-arsphenamine should not be used, but courses of bismuth, alternated with mercury rubs, or rest periods of two or three months, should be employed indefinitely.

In patients who are not completely free from oedema or slight exertional dyspnea when ambulatory, bismarsen (bismuth arsphenamine sulphonate) is the arsenical of choice. It is given intramuscularly at four or five day intervals, beginning with a dosage of 0.05 grammes and gradually increasing until 0.2 grammes are being given. If no reaction occurs, the course may be continued for twenty to forty injections.

In the presence of coronary stenosis many doubt the advisability of ever using neo-arsphenamine, except possibly in younger patients with good cardiac reserve. In old men with arteriosclerosis, it is of course advisable to be no more strenuous in treatment than to prescribe mercury and iodides by mouth. In the presence of severe renal impairment, mercury and bismuth should not be given. Small doses of bismarsen or neo-arsphenamine must be used from the outset.

When neurosyphilis is a complicating factor, which it is in roughly 35 percent of cases, the heart must be considered first. If it is thought advisable to use tryparsamide later, it must be remembered that this drug has no therapeutic benefit for the heart. Occasionally, under special circumstances, a patient with general paresis will have to be nursed through a course of malarial therapy, and the anti-luetic treatment for the heart be carried out afterwards.

Patients with cardiovascular syphilis must be advised about general care. They should avoid sudden effort. They should be transferred from manual labor, if so employed, to a sedentary occupation. An ever watchful eye should be kept upon them for signs of decompensation.

Finally, do not attempt to reverse a positive Wasserman by treatment in cardiovascular syphilis; it tends to remain positive indefinitely.

Prognosis.

The prognosis in cardiovascular syphilis is very poor in untreated cases. The patients may die suddenly or gradually from congestive heart failure. Moore and his co-workers have found that the average duration of life for patients with aortic regurgitation is thirty months, in patients with aneurysm, nineteen months. Treatment increases the life expectancy to seventy-one months in the former group and to seventy-five months in the latter. In patients with simple aortitis[3], that is, before coronary stenosis, regurgitation or aneurysm have developed, treatment provides a life expectancy of eight years. It is possible that, when aortitis is diagnosed more generally and earlier, results will improve accordingly.

Not only is life lengthened by treatment, but symptoms are relieved in a large percentage of patients. A great many are enabled to carry on at gainful occupations for an extra five years, and indeed some who are unable to carry on at manual labor can return to a sedentary occupation.

Attention is drawn to the fact that fourteen to seventeen percent of untreated syphilitic patients develop cardiovascular syphilis; that in any large series of cases of cardiovascular syphilis very few, if any of the patients, can give a history of anything approaching adequate early treatment. It has been computed that only one-half of one percent of adequately treated patients with early syphilis will develop cardiovascular syphilis. Hence, we should strive to ensure the adequate treatment of our early cases; and, in this country the onus of this responsibility rests largely on the general practitioner.

In conclusion, it is urged that the value of treatment in cardiovascular syphilis is apparent.

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Congenital Anomalies of the Intestinal Tract

With Report of a Case of Non-Rotation

By

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The incidence of congenital anomalies in the intestinal tract is not frequent, but not so rare that one can afford to overlook their possible existence. Not infrequently we are called upon to interpret atypical signs and symptoms which cannot be satisfactorily explained by our knowledge of normal anatomical facts, e.g. an acute abdomen with local signs simulating an acute appendix in a case who has previously had an appendectomy, or a case diagnosed as acute appendicitis and the appendix found with little or no pathological change at operation. In each incidence the possibility of an inflammatory Meckel's diverticulum must not be overlooked.

We have recently met with a series of intestinal abnormalities, among them a case of non-rotation of the primative intestine tract, a case of Hirschsprung's disease, two or three of acute Meckel's diverticulitis, one of imperforate anus, etc. The case of non-rotation we considered might be of sufficient interest to report, and at the same time it might be of some value to discuss the subject in a broader way and mention some of the other abnormalities of congenital origin.

In a general way it may first be stated that departures from the normal position are more frequently found in the colon, whereas developmental defects of the canal itself more frequently involve the small intestine.

To fully understand and to be conversant with these conditions, an occasional review of the underlying embryological factors is essential. Not infrequently an acute condition may demand a practical knowledge of congenital anomalies under urgent circumstances. It is therefore well to be familiar with the more common types and to have a working knowledge at least of the rarer types such as that of non-rotation, which of course means that the cæcum and the appendix are to be found in the left lower quadrant. When the clinical pathology in any acute case does not explain the symptoms for which the operation was undertaken, one should always look for the real cause before the abdomen is closed.

Fortunately, not all anomalies produce acute conditions. Others produce so typical a clinical picture that the diagnosis is obvious. In this latter category, one might mention imperforate anus. The absence of an external opening at the anal dimple leaves nothing difficult from a diagnostic standpoint. In the majority of these cases the distal loop of bowel will be encountered within two or three c.m's of the anal dimple. If difficulty is found in locating it, a colostomy may be done in the meantime. It is to be remembered, however, that infants stand operative proceedings poorly. The simplest procedure is always to be chosen.

Of the congenital anomalies not likely to produce acute conditions, we may therefore mention Herschsprung's disease, umbilical fecal fistula, segmental areas of intestinal stenosis, double barrelled colon, etc.

These may be discussed as chronic conditions not so obvious at birth, but as time passes on, through the months or years of their existence, a clinical picture is established which facilitates or makes the diagnosis easy. It may be argued that Hirschsprung's disease is not a congenital disease, but that it develops as a result of stenosis in the distal colon. From all practical standpoints it is a congenital disease, and was first described as such by Hirschsprung "as a congenital iodiopathic dilatation of the colon." His original classical description[1] of the disease leaves little to be added, and is well known to all. The colon assumes unbelievable dimensions, obstipation is pernicious, and normal evacuations never occur. The outstanding pathological features are tremendous dilatation and hypertrophy of all the intestinal coates. The condition is more frequent in males. In spite of the obstipation and infrequent evacuations, the patient is usually well nourished, and carries on with this handicap in surprisingly good health.

The treatment of colectomy carried with it a high mortality and is now about supplanted by neurectomy and sympathectomy[2]. Beneficial results have recently been reported by the use of parathormone[3].

Suffice it here to state that the chronic abnormalities are usually of long standing, when we see them they rarely are emergency procedures, and as such they afford the advantage of time for study, reference and diagnosis. An x-ray picture after emptying the colon by enemas and irrigations, and subsequent barium enema leaves nothing in doubt about the diagnosis. A useful tip learned from the mother of one of these patients is to insert the rectal tube high up into the recto-sigmoid segment for best results in attempts to empty the colon.

The appearance of the abdomen in Cœliac Disease may at first inspection so closely resemble the abdomen of Hirschsprungs as to cause diagnostic difficulty. Some clinical points of difference are:— The child with cœliac disease is more poorly nourished. Nothing abnormal has been noticed at birth or in the earlier months of life. There is no visible peristalsis, the stools may be frequent. They are small, foul and porridge-like, with a very high fat content. There is a typical wasting in the gluteal region. The skin hangs down in a bag-like fashion due to the lack of stored fat. This lack of subcutaneous fat deposit is to be noted in other fat storage stations of the body. The treatment is dietetic and the outlook good.

Two years ago, we had a patient on the wards who complained of two previous attacks of colicky pain in the abdomen associated with blood in the stool. A most painstaking examination revealed no possible source of the blood. I remembered having heard Doctor Charles Mayo remark that recurrent colicky pains in a male patient, associated with blood in the stool should arouse one's suspicion of a meckels diverticulitis, if every other conceivable source is eliminated. The patient submitted to operation on the chance that we might find the cause if our recorded pre-operative suspicion was not confirmed. At operation we found and excised an inflammed Meckels diverticulum. The patient has had no recurrence of symptoms.

Of the congenital defects that may become acute before they are discovered perhaps Meckel's diverticulum is the commonest. This condition is the result of an incomplete obliteration of the vitello-intestinal duct. It is to be found in the distal, two or three feet of the ileum; it is really a blind pouch on the antimesenteric border of the ileum, and may be adherent to the umbilicus. In excising an umbilical fecal fistula of congenital origin always look for the pouch-like diverticulum. It is well to remember that the existence of one congenital defect does not exclude the presence of another, but rather increases the possibility. Not so long ago while excising a patent urachus we looked for and found a Meckel's diverticulum. More than once when the clinical pathology of an appendix did not satisfactorily explain the acute symptomatology a search along the distal segment of ileum has been rewarded by the finding of an acutely inflamed or a strangulated Meckel's diverticulum. A discovery of very urgent importance, and not to be overlooked.

Other congenital abnormalities belonging to this category are: Mobile cæcum, congenital elongation of the mesentery — predisposing to volvulus; complete or incomplete transposition of viscera, non-descent of the cæcum — faulty or non-rotation of the colon.

The particular congenital anomaly I wish to call attention to at this time is that of non-rotation, with absence of the normal transverse colon and omentum. It necessarily follows that the cæcum and appendix under such circumstances occupy a position in the left lower quadrant. The explanation is made clear by an understanding of the embryolical factors producing it.

For a complete account of the development and the normal rotation of the primitative gut, you are recommended to refer to a text-book on embryology or anatomy. A very comprehensive account illustrated by diagrams is to be found in Cunningham's anatomy, page 1106.

Suffice it here to say that in early fœtal life there is no distinction into small and large bowel. The alimentary tract is simply represented by an almost straight tube which lies in the left cavity with its convexity towards the umbilicus, through which the vitelline duct passes to the yolk sac. The first indication of the formation of large bowel is in the form of a budding or an outgrowth from the primitive tubular midgut at a site distal to where the vitelline duct comes off. This original outgrowth becomes the future cæcum, and is the startingpoint for the development of the colon. It begins low down in the abdomen and ascends as its length increases, but always maintaining a position to the left of the spinal column until the normal phenomenon of rotation alters the entire position of the primitive canal.

This alteration or change of position is accomplished by a rotation of the whole alimentary loop with its mesentery around the superior mesenteric artery as an axis. The result of this rotation is that the original right side of the loop of gut and mesentery becomes the left side and the beginning of the large intestine is carried across the duodenum which explains the position of the duodenum behind the transverse colon in the adult. At the same time the cæcum now comes to be near the middle of the abdomen below the liver. This transformation occurs about the end of the third fœtal month. As growth progresses the cæcum descends until at birth it occupies its normal position in the right lower quadrant. The small intestinal tube continues to grow in length and is thrown into coils until the normal length is attained.

Occasionally this normal process of rotation fails to occur and in such an event we find a complete absence of colon in the right side of the abdomen. The cæcum and appendix continue to occupy their original embryological position in

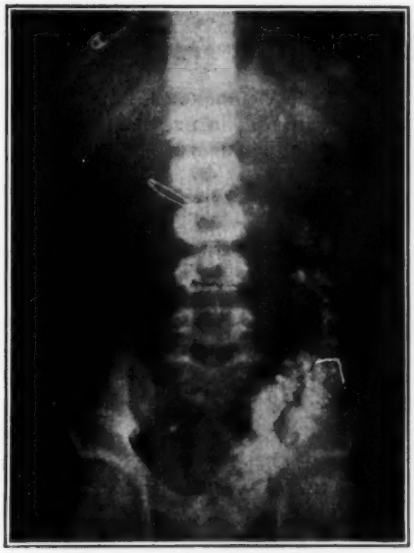
the left lower quadrant. The condition is referred to as non-rotation as opposed to faulty or partial rotation when the cæcum is found in the adult high up under the liver, and has failed to descend. This condition of non-descent is more frequently found than that of non-rotation. A point of some clinical importance. This anomoly though rare, is interesting from an etiological standpoint, and important from an operating standpoint.

Case Report.

The case is that of a boy 15 years of age, thick set, well-developed, who had a history of recurrent abdominal pain with vomiting on a recent occasion. The crampy pains had recurred at frequent intervals in the past year, but were more persistent prior to admission and radiated across the lower abdomen.

EXAMINATION: Negative, except for the abdominal condition; Temp. 99 1/5; Pulse 84; Abdomen rather distended with slight rigidity; tenderness in the lower abdomen with maximum tenderness in the right lower quadrant. Rectal examination was negative but for a mass of localized tenderness. Bowels were regular normally; leucocyte count 10,800; urinalysis negative; diagnosis appendicial colick.

OPERATION: A small McBurney incision. We were unable to find the cæcum, and with the flat brass retractor inserted liverwards, the absence of cæcum and ascending colon could be demonstrated. A congenital condition was suspected. Because of the greater frequence of non-descent of the cæcum and the fact that a small nodule suspected as being the tip of the appendix could be felt with the finger just under the liver, a high right rectus incision was made. The nodular mass turned out to be a small inflammatory gland. The stomach was visualized so that we might follow the gastro-colic omentum down to the transverse colon. The latter, as such, was absent, and of course no omentum was present. The cæcum was found in the lower left quadrant. A greatly elongated mesentery allowed one to deliver the segment through the upper right rectus incision. The appendix was curled up and contained a concretion, otherwise looked normal. It was removed. One had noted some dilitation and inflammation of a segment of ileum. A search was made for the cause and particularly for a Meckel's diverticulum—which was not present.



X-ray photograph after operation showing caecum on left side medial to the descending colon.

The colicky pains are more likely to have been due to a partial volvulus, or kinking of the bowel due to the long free mesentery rather than an appendicial colick as diagnosed.

Recovery was uneventful. A post-operative barium series and barium enema was obtained. The accompanying miniature was made from the x-ray film. This is a typical example of the congenital anomaly of non-rotation of the colon.

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3. Sheldon & Kern.

Victorian Order of Nurses

During the year we opened two additional Well Baby Conferences where no other organization was giving this service, viz., at Fort Garry and East Kildonan. The response has been gratifying. In East Kildonan, which opened in April, 79 babies have registered, with an average weekly attendance of 12. In Fort Garry, which opened in May, there was a registration of 57 babies, with an average weekly attendance of 8.3. St. James had an enrolment of 204 babies at the beginning of 1934. There were 114 new cases admitted to the conference, and 103 infants, having reached their second birthday, were transferred to the supervision of the Health Unit at St. James.

The term, "Well Baby Conference," implies no doctor in attendance, but on 147 occasions the nurse in charge asked the mother to consult the family physician, or through some other source to get medical advice regarding her infant.

Mothercraft and Home Nursing Classes. During the year one short course of four lessons in First Aid was given to a C.G.I.T. group, and seven courses of 12 classes each in Mothercraft were given, with a total enrolment of 126. Examinations were held at the close of each course and diplomas presented to those who successfully passed the tests.

Editorial and Special Articles

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The King George V. Silver Jubilee Fund for Cancer in Canada

Notice from the Canadian Medical Association

His Majesty, the King, has graciously given his consent to the twenty-fifth anniversary of his accession to the throne being recognized in Canada by way of a campaign to raise funds to combat cancer, the campaign to be in charge of His Excellency, the Governor-General of Canada. His Excellency has announced that the campaign will be inaugurated at an early date and will close on May 5th. It is hoped that all Canadian citizens will desire to contribute to the fund, having regard to its testimonial character for so beloved a sovereign, and the purpose for which the fund is to be used, namely, to combat the ravages and growing menace of the dread scourge, cancer.

When the fund is completed, it is to be turned over to a Board of Trustees of seven men, as follows:—

The Chief Justice of Canada (Chairman)
The Prime Minister of Canada
The Leader of the Opposition
The Minister of Health of Canada
The Chairman of the Cancer Committee of the Canadian Medical Association.
A representative of the French Speaking Medical Schools
A representative of the Health Committee of the Canadian Life Insurance Officers' Association.

The Canadian Medical Association is honoured in having been invited to occupy a seat on this Board, and is particularly pleased that that place is to be filled by Dr. A. Primrose, of Toronto, Chairman of the Association's Study Committee on Cancer.

The announced objective of the fund is two-fold —(1) to carry on an educational campaign to assist the medical profession in their fight against cancer; and (2) to carry on an educational campaign to enlighten the laity as to the part which they should play in combatting cancer. With the magnificent assistance of the Sun Life Assurance Company of Canada, the Canadian Medical Association carried on, over a period of seven years, a plan of extra-mural post graduate medical education covering the entire Dominion. The value of this service has long since been fully recognized by the medical profession. It is hoped that, when the cancer fund is available, the Board of Trustees will invite the Association to resume its extra-mural work by assuming the responsibility of carrying to the medical profession of Canada information dealing with the manifestations of cancer in all its forms and phases.

Realizing the full significance of this campaign, it is hoped that the medical profession will support it most heartily, not only with personal contributions but by enlightening the people in their respective communities as to the opportunity which is being given to them to pool some of their resources to wage war upon cancer.

Joint Meeting of the Manitoba and the Ontario Medical Associations

To the Members of the
Medical Profession of Manitoba.

Your attendance is earnestly requested at a joint meeting of the Ontario Medical Association and the Manitoba Medical Association on May 28th, 29th, 30th and 31st, 1935. This meeting is unique as it is the first time in history that these two associations will have met together. This event in Medical History will take place at the Head of the Lakes — Fort William and Port Arthur.

How will you reach the Convention Cities? From the East you have a choice of:

(1) All rail—either C.P.R. or C.N.R.

(2) Lake and Rail. The Convention official boat leaves Port McNicoll on Sunday, May 26th, a train leaving Toronto that afternoon. This puts you in the Lake Ports early on Tuesday morning, May 28th. The alternate route is via Sarnia, leaving Saturday and arriving Monday.

(3) Motor trip via Duluth.

(4) By air—for those who are air-minded.

From the West you have a choice of:

(1) All rail—C.P.R. or C.N.R.

(2) Motor—choice of via Duluth or Trans-Canada Highway.

(3) Air.

Rail and water rates will be as follows: Fare and a quarter. This means you buy a standard certificate to the Head of the Lakes and on presenting same to the transportation offices you are enabled to return home for one quarter usual fare. Berths and meals will, of course, be extra.

Now, as to accommodation. Fort William and Port Arthur are well-known convention cities and have ample accommodation for all those who come.

A splendid scientific programme has been arranged. You are assured of true Western hospitality. So make your plans NOW and be with us from May 28th to 31st.

Cordially yours,

CRAWFORD C. McCULLOUGH, M.D.
President
Thunder Bay Medical Society
Fort William and Port Arthur.

A. T. GILLESPIE, M.D.
Chairman of Publicity Committee.

Minutes of Executive Meeting

MINUTES of a meeting of the Winnipeg members of the Executive of the Manitoba Medical Association, held in the club-rooms of the Medical Arts Building, on Tuesday, February 12, 1935, at 6.30 p.m.

Present.

Dr. J. C. McMillan	- - Chairman
Dr. J. S. McInnes	Dr. F. A. Benner
Dr. F. G. McGuinness	Dr. W. G. Campbell
Dr. W. E. R. Coad	Dr. Lennox Arthur
Dr. R. R. Swan	Dr. Ross Mitchell
Dr. W. H. Secord	Dr. G. S. Fahrni
Dr. E. S. Moorhead	Dr. F. W. Jackson

Dr. T. C. Routley, General Secretary of the Canadian Medical Association, and Dr. J. C. Gillie, President of the Ontario Medical Association, were present as guests of the Association.

The First Vice-President being absent from the city, it was moved by Dr. R. R. Swan, seconded by Dr. F. G. McGuinness: THAT Dr. J. C. McMillan be appointed chairman of the meeting. —Carried.

Health Week.

Letter was read from Mr. Walter Johnson, Supervisor of the Back-to-the-Land Assistance Association, under date of February 1st, with reference to a proposed health week to be put on by them in April. The consensus of opinion of the meeting was that the Association was not prepared to officially back such a proposition at this time, and it was moved by Dr. F. G. McGuinness, seconded by Dr. R. R. Swan: THAT the chairman represent the Association at any future meetings held to discuss the matter and express the views of the Association. —Carried.

Municipality of Woodworth.

Dr. Moorhead, Chairman of the Committee on Sociology, reported as follows with reference to health insurance in the Municipality of Woodworth. The College of Physicians and Surgeons could not see their way fit to contribute the sum of $2,000 towards the trial of this scheme. The same thing was occurring now as had occurred at previous times, namely, there were three interests involved—the municipality, the province and the medical profession, and none of them seemed to be prepared to assume the proper financial burden to give the scheme a proper trial. It was absolutely necessary for it to be tried out in order that the much needed information could be obtained.

Dr. Routley then spoke in reference to the discussion of health insurance in the East. He informed the meeting that the Prime Minister was going to bring down a bill on health insurance. He also mentioned the resolution sponsored by Mr. Spencer of Alberta, asking that more money be spent on public health. The new Minister of Public and National Health had decided to hold a conference of all the Provincial Ministers of Health in order that some definite set-up would be made by the Federal Departments in reference to health administration. He suggested to the Executive that it was the duty of the medical association to express to their local Minister of Health the requirements in this connection.

Dr. Routley was asked the question as to the feeling of the men in the East in reference to health insurance, and replied that, in a questionnaire sent out in Ontario, it would appear that the medical profession were overwhelmingly in favor of health insurance.

Dr. Secord asked what should be presented to the Minister of Health in reference to our attitude on health insurance. Dr. Routley suggested that, in view of the fact that we endorsed the principles of the report of the Committee on Econ-

omics of the Canadian Medical Association, this might be presented to the Minister for his information.

With reference to the Woodworth plan, Dr. Routley was of the opinion that it would be very advisable to have it tried out on a small scale in this way, in order that we might obtain information as to the actual cost of a complete medical service.

Dr. McInnes expressed the opinion that the approach to the College of Physicians and Surgeons had not been properly made, and that there had been too much hurry in the matter, so that the members of the Council were not as fully conversant with the scheme as they should be.

Dr. Campbell explained the steps he had taken to notify the members of the Council as to what it had been asked.

Dr. Routley also explained in detail the present status of medical care for the unemployed in Ontario, pointing out that the Ontario Government was going to grant to the Ontario Medical Association the sum of 25c per person per month for a general practitioner service, including drugs.

Radio Broadcasting.

Dr. A. J. Swan then addressed the meeting with reference to radio broadcasting, reading correspondence which he had been given between the Canadian Radio Broadcasting Commission and the Canadian Medical Association. This particularly referred to the "Cystex" and "Vapex" programmes.

Dr. Routley read the minute in the proceedings of Council with reference to the matter, and following discussion, it was moved by Dr. W. G. Campbell, seconded by Dr. F. A. Benner: THAT Dr. Routley take this matter up again with the Canadian Radio Broadcasting Commission to see if all such radio broadcasting could not be deleted except that under the official health departments. —Carried.

Fort William Meeting.

Dr. J. C. Gillie, President of the Ontario Medical Association, then spoke with reference to the forthcoming joint meeting at Fort William. He figured that the attendance was going to be quite large and that the programme was one of the best ever prepared for an Ontario meeting. He hoped that Manitoba would be able to send a good representation.

Constitution of C.M.A.

Dr. Routley spoke in reference to the above, reading extracts from the report of the committee now considering the revision of the constitution. He was of the opinion that the Canadian Medical Association should be all inclusive, meaning that the provincial associations should be branches of the parent organization.

Report of Committee on Maternal Mortality.

Dr. Lennox Arthur, Chairman of the above Committee, reported as follows. He had received a suggestion from Dr. O. C. Trainor, Chairman of the Health Committee of the Central Council of Social Agencies, that the pre-natal and post-natal letters now being distributed by the Canadian Council of Social and Family Welfare, either directly to individuals writing for same or through the local departments of health, might be more advantageously sent out through the local physician, and in this way it might be assured that the expectant mother would receive very adequate pre-natal and post-natal care. (Copy of report on file).

Dr. Routley, when asked to express his opinion on the subject, suggested that possibly the Canadian Medical Association would consider the printing of any such literature which this Association might request, and might take the responsibility of supplying same to doctors on request, so that the local doctor could himself, under his own signature, distribute such literature to those requiring it.

After further discussion, it was moved by Dr. G. S. Fahrni, seconded by Dr. E. S. Moorhead: THAT the Maternal Mortality Committee be asked to consider the matter further, and evolve a plan to take care of the matter in a proper manner, looking to the Canadian Medical Association for help. —Carried.

The meeting then adjourned.

Memorandum Re. Canadian Medical Association – Provincial Branches

Report from Secretary of Canadian Medical Association

At the annual meeting of the Manitoba Medical Association held in Winnipeg on September 10, 11 and 12, a suggestion was made that medical organization in Canada might view with approval a plan which has been so successful for a century in the British Medical Association whereby the integral parts of the parent Association are known as Branches and Divisions, even going so far afield as Australia and South Africa where the Associations are known respectively as the British Medical Association (Australasian Branch) and the British Medical Association (South African Branch). The day following the provincial meeting, a meeting was held of the outgoing and incoming Executive Committees. At this meeting, a resolution was presented and adopted to the effect that the group present would favour the Manitoba Medical Association changing its name to "The Canadian Medical Association (Manitoba Branch), if the other provincial associations in Canada adopted a like course. Our President, Dr. J. S. McEachern, and the General Secretary, who were then commencing a tour of Canada, undertook to carry this message to the other provinces. We now report upon the reception which the suggestion received.

On September 15th, we attended a meeting in Calgary with representatives of the Executive Committee of the Alberta Medical Association and members of Council of the College of Physicians and Surgeons of Alberta. Here a resolution was adopted unanimously approving of the principle of the Canadian Medical Association (Alberta Branch). (At a subsequent meeting in Red Deer, Alberta, on October 4th, with a larger number present from Council and the Executive Committee, the resolution was reaffirmed).

Proceeding to British Columbia to the annual meeting of the British Columbia Medical Association held in Kamloops on September 17th and 18th, a resolution was passed approving of medical organization in British Columbia being known as the Canadian Medical Association (British Columbia Branch). During the latter part of that week, a meeting of the Vancouver Medical Association and a meeting of the Victoria Medical Society enthusiastically approved the same resolution.

Proceeding to Saskatchewan, we met the Executive Committee of the Saskatchewan Medical Association in Regina on September 25th. At this meeting, a resolution was unanimously adopted, favouring the Saskatchewan Medical Association changing its name to the Canadian Medical Association (Saskatchewan Branch). That evening, the Regina and District Medical Society heartily concurred in the suggestion.

On Friday, October 26th, in Montreal at the Cercle Universitaire, we met the Executive Committee of the Province of Quebec Medical Association. While no formal resolution was passed, the members of the Committee present appeared to be heartily in accord with the suggestion that the Provincial Association of the Province of Quebec should be known as the Canadian Medical Association (Quebec Branch). That evening, at a meeting of the Montreal Medico-Chirurgical Society, while no official resolution was passed, evidence appeared to be abundantly present in support of the proposal. The following week, resolutions of approval were passed by the Ottawa Medico-Chirurgical Society and the Medical Society of Sherbrooke, Quebec. In Quebec City, due to the fact that we were there on a religious holiday, it was only possible to get together a small group; and, while they did not feel qualified to pass any formal resolution, every man present expressed his approval of the proposal.

A section of the medical profession of New Brunswick was met in Saint John on Friday, November 2nd, when there was a splendid attendance. Here, a resolution was adopted instructing the Provincial Association, through its Executive Committee, to carefully study the proposal. Several members, speaking to the resolution, heartily endorsed the proposal, while three others who spoke expressed the opinion that it would require very careful consideration, having regard to the change of name which might necessitate going to the Government for permission to do so, and the fact that the name, "New Brunswick Medical Society" is dear to the hearts of their members and there might be some reluctance to giving it up.

On Saturday, November 3rd, at a largely attended meeting in Moncton, the proposal to call the Association Canadian Medical Association (New Brunswick Branch) was received with unanimous approval.

On Monday, November 5th, at a meeting attended by close upon one hundred in the City of Halifax, it may be said that the proposal was discussed at great length by a number of men. In every single instance, heartiest approval was expressed for national unity and consciousness; and, although the Medical Society of Nova Scotia is more than eighty years old, the group unanimously carried the resolution favouring the adoption in Nova Scotia of the name "Canadian Medical Association (Nova Scotia Branch)."

Proceeding on November 6th to Charlottetown, we met at dinner the Council of the College of Physicians and Surgeons and the Executive of the Prince Edward Island Medical Association. At this meeting a resolution was moved by the Prime Minister of the Province, the Honourable Dr. MacMillan, expressing complete accord and approval, and hoping that the profession across Canada would recognize the opportunity and the obligation of adopting a plan which would make us all members of a great national organization. A resolution of approval was passed unanimously, suggesting that in the Island, the name be changed to Canadian Medical Association (Prince Edward Island Branch).

On Tuesday, November 13th, we met the Board of Directors of the Ontario Medical Association. At this meeting, the following resolution was unanimously passed:—

> "That, whereas Dr. J. S. McEachern, President of The Canadian Medical Association, has placed before the Board of Directors of the Ontario Medical Association, a proposal that the various Provincial Medical Associations become branches of the Canadian Medical Association; and whereas the advantages of the proposal to the profession at large have been set forth, therefore, be it resolved that this Board of Directors of the Ontario Medical Association approve of the principle submitted, with a view to submitting it to Council of the Ontario Medical Association for their consideration and action. Further, be it resolved that the Executive Committee of the Canadian Medical Association be requested to submit a well studied plan by which the desired co-operation might be brought into effect."

Throughout the tour, we met more than one thousand medical practitioners. In this report, we have recorded bare facts, but the report would be incomplete if we failed to make reference to the countless conversations we both had with many of our colleagues, when, over and over and over again, it was demonstrated to us that at least a cross section of the profession whom we met were in unity with regard to the advisability and advantages of complete federation of the medical profession in Canada.

It now remains for the Executive Committee of the Canadian Medical Association to work out, through its appropriate committees, a plan of procedure which will be submtited to each of the nine Provincial Medical Associations. Already, the Committee on Revision of By-Laws of the C.M.A. has this matter under advisement, and, when its suggestions have been dealt with by the Executive Committee of the Association, they will be ready for submission to the provinces.

For the information of all the profession, it should here be emphasized that, if and when the plan is adopted nationally, it will not in any way interfere with provincial autonomy, nor will it permit of any outside interference in provincial matters. It should be possible to have for each province a basic constitution to which may be added By-Laws and procedure particularly applicable to that province. The plan in its final form must be acceptable to the provinces or of course it will not be adopted. We should, surely, with composite thinking and acting, be able to develop plans which will implement what appears to be a more or less unanimously accepted desire on the part of the medical profession from Coast to Coast. If we sympathetically bend our efforts towards a fulfilment of an ideal, it can be worked out. This is our ambition and our goal.

College of Physicians and Surgeons of Manitoba

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Vice-President

H. O. MCDIARMID, M.D. (Man.), Brandon.

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A. E. MCGAVIN, M.D., C.M. (Man.)
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W. H. SECORD, M.C., M.D., C.M. (McG.)
D. G. ROSS, M.D., C.M. (Man.)

DISCIPLINE COMMITTEE

The Discipline Committee was instructed by the Council of the College of Physicians and Surgeons of Manitoba to inquire into the charge of unprofessional conduct against Dr. ....., by the Workmen's Compensation Board, the charge being as follows:

"WHEREAS it is alleged that you, ..., a medical practitioner registered under "The Medical Act", are liable to have your name erased from the register of the College of Physicians and Surgeons of Manitoba under the provisions of the said Act by reason of infamous or unprofessional conduct, or of professional misconduct so gross as to disqualify you from practising medicine or surgery, in that you did during the months of August and September, A.D. 1934, falsely represent to the Workmen's Compensation Board of the Province of Manitoba by the making of certain statements and reports and the rendering of an account for professional services that you had treated one, ..., of ....., Winnipeg, Manitoba, at various times between July 18th and July 24th, 1934, and including these dates, when in fact you did not treat the said ..... for said illness, and that you obtained thereby from the said Workmen's Compensation Board the sum of Fifteen Dollars ($15.00).

"NOW THEREFORE TAKE NOTICE that pursuant to the provisions of 'The Medical Act' and amendments thereto, a Committee of the Council of the College of Physicians and Surgeons of Manitoba will make an inquiry, with the above subject matter, to ascertain the facts relating to your said alleged infamous or unprofessional conduct or professional misconduct, at Room 605 in the Medical Arts Building, corner of Kennedy Street and Graham Avenue, in the City of Winnipeg, in Manitoba, on Saturday, the 29th day of December, 1934, at the hour of 2.00 o'clock in the afternoon.

"AND FURTHER TAKE NOTICE THAT in the event of your non-attendance at the time and place above mentioned the said Committee will proceed with the said inquiry in your absence and make their report of the facts to the said Council without further notice to you."

The Discipline Committee met at the office of the Registrar on December 29th, 1934, to take evidence. The Counsel for the College of Physicians and Surgeons, the complainant, the defendant and his Counsel, were present in person. Also the patient .....

The Discipline Committee heard the evidence adduced by the Complainant in support of the charge. That of the witness, ..., as to treatment received, and that of the Defendant in defence of the charge, under examination by Counsel for the College of Physicians and Surgeons.

In view of the seriousness of the charge, the Committee was of the opinion that the Council might find it advantageous to have a complete copy of the evidence before them, and this is submitted with the report. In summing up, the Committee is therefore of the opinion that the charge of grave professional misconduct has been substantiated, and find as follows:

1. That the charge against the accused has been proved and admitted by himself.
2. That the accused altered an official document in a material way by signing his name over an erasure.
3. That the accused charged for house visits he did not make.

In view of these findings, we, the Discipline Committee, venture to recommend that the name of the accused be erased from the Register of the College of Physicians and Surgeons of Manitoba, for a period of at least one month, and that the name be not restored to the Register until the full fee of One Hundred Dollars ($100.00) be paid.

EXECUTIVE MEETING

A meeting of the Executive Committee of the Council of the College of Physicians and Surgeons of Manitoba was held January 19th, 1935, at 7.30 p.m., in the Registrar's office, 605 Medical Arts Building, Winnipeg.

Members present were:

Dr. William Turnbull
Dr. L. D. Collin
Dr. W. H. Rennie
Dr. H. O. McDiarmid
Dr. W. G. Campbell.

Dr. William Turnbull was in the chair.

The agenda was as follows:

1. Consideration of Report of Discipline Committee, re. Dr. ....., Winnipeg, Man.
2. Re. advertising of Dr. ....., Winnipeg, Man.
3. Deputation from the Committee of Sociology.
4. Interim report on Prosecutions:
   (a) Re. Thonne, Winnipeg, Man.
   (b) Re. Lozo, Winnipeg, Man.
   (c) Re. Oshanek, Winnipeg, Man.
5. Report re. erasure of Dr. ....., Brandon, Man.
6. Re. Question of Further Appointments to the Committee on Pharmaceuticals.

1. Consideration of Report of Discipline Committee, re. Dr. ....., Winnipeg, Man.

After thorough consideration of the report submitted by the Discipline Committee, it was moved by Dr. McDiarmid, seconded by Dr. Rennie:

"That the report of the Discipline Committee be accepted and acted upon as per their recommendation, re. Dr. ....., and the Registrar be instructed to erase his name from the Register, and that the name be not restored to the Register for at least one month, nor until the registration fee of One Hundred Dollars be paid." Carried.

2. Re. Advertising of Dr. ....., Winnipeg, Man.

Dr. ..... appeared with his Solicitor, and the individual who wrote the article in the paper, "The Polish Times."

The Committee questioned Dr. ....., and the individual responsible for the article in "The Polish Times," under date of October 16th, 1934. Dr. ..... presented copies of several letters he had written to Editors of papers requesting that no publication be made in reference to his name. These copies were dated subsequent to his former appearance before the Executive Committee, on a similar complaint, namely, advertising.

The Committee then excused Dr. ....., his Solicitor, and the author of the article.

Discussion on the matter then ensued, and the following motion was submitted:

Moved by Dr. Rennie, seconded by Dr. Collin: "That the Executive Committee recommend no action, as Dr. .....'s explanation had been satisfactory." Carried.

3. Deputation from the Committee of Sociology.

A deputation from the Committee of Sociology, consisting of Dr. E. S. Moorhead, Dr. Ross Mitchell and Dr. J. Currie McMillan, appeared before the Committee.

The matter in point was in connection with the experimental trial of Health Insurance in the Municipality of Woodworth.

Dr. Moorhead addressed the meeting explaining that the cost of the proposed Health Insurance was estimated at $12,000.00 for a year's trial. The Committee had approached the Provincial Government to assist in financing the proposition. At that time, the Government was willing to subscribe only $1,500.00, and the Municipality $5,000.00. The Committee proposed to the Government the sum of $3,000.00 if the College of Physicians and Surgeons would contribute $2,000.00 for the first year. The Government was willing to accede to this proposition. That would leave the Municipality to subscribe $7,000.00.

Dr. McMillan discussed the costs, advantages, and desirability of this experiment.

Dr. Mitchell spoke on the desirability of a trial of such insurance with a possibility of arriving at definite information as to the cost of Health Insurance on a similar basis, if and when, it were desirable, or necessary to inaugurate such a plan for the whole Province.

After considerable discussion, the Executive Committee requested that a meeting be assembled of the Committee of Sociology and all the City Members of the Council of the College of Physicians and Surgeons of Manitoba, including representatives from St. Boniface, Manitoba, and if possible, Selkirk, Manitoba, for the purpose of familiarizing those members of the Council with the various angles of this project.

The Executive Committee felt that they had no power to contribute a sum of $2,000.00, and considered it advisable to have the opinion of the City Members before considering calling the Council together to pass judgment on a proposition, with the details of which they were not familiar.

It was left to the Registrar to assemble the local representatives at as early a date as possible.

4. Interim Report on Prosecutions.

(a) Re. Thonne, Winnipeg, Man.

The Registrar reported that Thonne had left the City, therefore, prosecution was in abeyance, and possibly terminated.

(b) Re. Lozo, Winnipeg, Man.

Information is being obtained, and the Registrar hopes that Court action may be taken in the near future.

(c) Re. Oshanek, Winnipeg, Man.

Information is being obtained, and the Registrar hopes that Court action may be taken in the near future.

5. Report Re. Erasure of Dr. ....., Brandon, Man.

The Registrar reported to the Executive the erasure of the name of Dr. ....., Brandon, Manitoba, for the non-payment of Annual Dues.

The Registrar requested the advice of the Committee on the publication of the proceedings against Dr. ....., Brandon, Manitoba, and Dr. ....., Winnipeg, Manitoba, in the "Manitoba Medical Review," and also notifying the various Departments and Organizations, and the Registrars of other Provinces, of the procedure carried out in reference to those two Doctors.

The Committee recommend that a publication be made in the "Review" of the Procedures, with the elimination of the names, and that the various organizations, namely, the Medical Societies, Hospitals, the Provincial Drug Association, the Department of Health and Public Welfare, the Recorder of Vital Statistics, the Winnipeg Health Department, the Compensation Board, the Department of Pensions and National Health, at Ottawa, the Dominion Police in Winnipeg, and the Registrars of the various Provinces of Canada, the Registrar of the General Medical Council of Great Britain, and the Registrar of the Medical Council of Canada.

6. Re. Question of Further Appointments to the Committee on Pharmaceuticals.

Dr. Campbell inquired if the Committee would deem it advisable to make further appointments to the Committee on Pharmaceuticals.

The Committee decided that at the present time, no further appointments would be necessary.

Adjournment.

The meeting then adjourned.

EXECUTIVE COMMITTEE

A meeting of the Executive Committee of the Council of the College of Physicians and Surgeons of Manitoba was held in the office of the Registrar, 605 Medical Arts Building, Saturday, February 16th, 1935, at 7.30 p.m.

The members present were:

Dr. C. W. Burns
Dr. W. G. Campbell
Dr. L. D. Collin
Dr. H. O. McDiarmid
Dr. J. S. McInnes
Dr. W. H. Rennie
Dr. William Turnbull.

Dr. Turnbull was in the chair.

Re. Grant to the Committee on Sociology, re. Health Insurance Plan Proposed for the Municipality of Woodworth.

Following the questionnaire sent to the members of the Council, in reference to the solicitation of the Sociology Committee that the College of Physicians and Surgeons contribute Two Thousand Dollars, for the Health Insurance plan proposed for the Municipality of Woodworth, and the feeling of disappointment on the part of the Manitoba Medical Association, it was felt that the matter be brought before the Executive Committee for the purpose of further discussion.

After the matter had been considered carefully, it was moved by Dr. McDiarmid, seconded by Dr. Rennie:

"That in view of the unfavorable report from the Council, the Executive is powerless in making this grant at the present time. The Executive wish to state that they are in sympathy with any scheme which will provide the medical profession with the data required, and wish to express our thanks and to assure the Committee on Sociology, that this matter will be fully presented and explained to the Council at the next meeting of the Council. We regret that we are obliged to leave this matter over for future consideration and decision of the Council." Carried.

Several other matters received the attention of the Committee.

Adjournment.

The meeting then adjourned.

Winnipeg Medical Society

The regular monthly meeting of the Winnipeg Medical Society was held in the Physiology Lecture Theatre of the Medical College on Friday, February 22nd, at 8.15 p.m. The programme was as follows:

1. "Report of 400 Cases of Icterus Neonatorum." —Dr. Norman Book.
2. "Tuberculous Peritonitis." —Dr. J. D. Adamson and Dr. Alex. Sinclair.

The Winnipeg General Hospital

The Board of Trustees of the Winnipeg General Hospital announce the appointment of:

W. A. McElmoyle, M.D. (Man.), F.R.C.S. (Edin.).
M. B. Perrin, M.D. (Man.), F.R.C.S. (Edin.).
A. W. S. Hay, M.D. (Man.). F.R.C.S. (Edin.).
John A. Hillsman, M.D. (M.C.V.), Ch.M. (Man.).

as Assistant Surgeons to the Honorary Attending Staff.

(Signed) G. F. STEPHENS,
Superintendent.

Department of Health and Public Welfare

NEWS ITEM

TRACHOMA IN THE INDIANS OF WESTERN CANADA: The following is the second and final instalment of a report written by Dr. J. J. Wall on "Trachoma in the Indians of Western Canada" which we published under "News Items" of the Department of Health and Public Welfare in the January number of "The Manitoba Medical Association Review."

"Many people hold the term 'granulated lids' to be synonymous with a blepharitis in which the small incrustations along the lid margin appear as 'granules' somewhat similar to small pieces of 'granulated' sugar. The term conveys little to the patient as to the seriousness of the disease. The profession would be well advised to abandon entirely the terms 'granular' and 'granulated' lids. It is to be urged that the term trachoma only, should be used to patients and the malignant and communicable character of the disorder emphasized.

"One of the most important steps toward the eradication of trachoma amongst the Indian people will be education. The fatalistic conception that, once the disease has been established, nothing can be accomplished other than awaiting the inevitable outcome, must be offset. Considering the mentality of these people, the results to date have well justified the efforts expended. Special attention is given to the older Indian and Medicine Man who is encouraged at clinics to note the manifestations and ravages of the disorder. Demonstrating a few children with normal eyelids together with a second group of positive cases who come from families where the disease has wrought havoc with vision, conveys the idea of the communicable nature. The abundant masses of soft gelatinous follicles in the lids of this group are drawn to their attention. These people realize the communicable character of diseases like small-pox, but had little conception that trachoma was of a similar nature. The importance of fingers, hands, towels and wash basins, in spreading the disease is emphasized.

"Improvements are frequently noted on a return visit to an area where many of the positive cases have since provided their own toilet articles.

"The old women are much more intractable in this respect than the older men. They view with suspicion any suggestions coming from a stranger and are inclined to scoff at anything savouring of advice. Other than through the influence of the husband, it will be most difficult to enforce the discontinuance of the practice of wiping the children's faces with the end of the head kerchief which is constantly used to mop the secretion from her own diseased eyes. Much less difficulty will be experienced with the younger mothers who have had an opportunity of training in the residential schools.

"The residential school should prove to be a most valuable asset in educating the rising generation to the danger of the disease and its manner of propagation. The importance of early and consistent treatment is learned by the pupils, many of whom are under treatment. Extreme care is exercised to render treatment as gentle and painless as possible.

"Criticism of this policy is justifiable on the basis that these cases are a grave menace to the non-infected pupils, and should never have been admitted to these institutions. The ideal would undoubtedly be trachoma-free schools. Returning these children to their homes would result in their securing little medical attention and the proper nutrition which is so necessary to supplement the former.

"The experience of other nations has demonstrated that once trachoma has been introduced to any great degree, the process of extermination has been measured in terms of years and not months. Since it has obtained such a foot-hold in the Canadian Indians, there is little evidence to presuppose that the disorder will be of any shorter duration. On the contrary, in addition to other factors, there must be overcome certain fundamental prejudices which are inherent in the Indian nature. The pupils of today will become the parents of tomorrow, and it is most essential that they secure enlightenment regarding the disorder. The school is the natural and most advantageous place from which to spread all propaganda.

"The common roller towel has been eliminated from these schools and each child has an individual towel, basin, and soap. The positive cases have their pillow sheets, towels, etc., marked with a large square of turkey-red unbleachable cotton percale. Strict discipline is maintained regarding the use of toilet articles. Presupposing infection during play hours in the late afternoon, each child who is negative receives prophylactic drops of zinc sulphate one-quarter per cent. (0.25 per cent.) each evening. This measure has proved quite effective to date. In addition to any other treatment all positive pupils receive at the same period trachomine ointment. Towels, handkerchiefs, etc., from the infected pupils are boiled separately for 20 minutes before being laundered. Antiseptics such as creolin, lysol, etc., and their derivatives are discouraged for laundry purposes as there is always a danger of over-confidence in their value. The extremely alkaline reaction of the water through chemical interaction seriously interferes with their antiseptic properties. Special regulations have been laid down with respect to the bathing of the trachoma patients. Every effort is made to protect the uninfected individual from accidently contracting the disorder. To date the regulations, wherever carried out, have proven quite satisfactory. Cases developing a corneal ulcer with consequent marked lacrymation with high index of infectivity, are especially guarded against.

"It might be of interest to discuss briefly the possible origin of trachoma in the Canadian Indians. Many of the more intelligent and older members of the Stoney and Cree nations believe the disease was introduced by infected Indians from the United States who accompanied the early traders from the American side into the southern parts of the Prairie Provinces and British Columbia. Many of these visitors remained and were absorbed into the Western bands. Some of the more responsible Indians claim this to be the manner in which trachoma was introduced to their people.

"That the Indians might have contracted the disorder from the earlier white settlers may be possible but is highly improbable. Many of these foreigners did not arrive in the country until after 1890, and it is scarcely conceivable that the disease could become so generalized throughout the West in such a limited period. Many of the older infected Indians maintain this eye trouble was present in their own families with the resultant blindness long before the advent of the European settler.

"Certain authorities claim that the American Indians were originally a group of nomad races from the plains of Mongolia, who crossed to the American continent in various huge migrations. Should this be true and one considers the incidence of trachoma in the Mongols, it is quite possible that the Indians have had the disorder from time immemorial. The presence of the disease in large numbers of people in the hinterlands of British Columbia could well be accounted for on these premises, as little fraternizing is encountered between the Indians to the east of the Rocky Mountains and those living on the western and Pacific

side. It is scarcely possible that one or other of these large groups of Indians differing entirely in mode of life, customs and language, would be responsible for the disorder in the other group. Quite compatible with the possible Asiatic origin of trachoma is the fact that many of the Indians held a fatalistic and stoical conception of the ultimate results to be expected in one who had the disease. From all observations they have no drugs of any value against the malady and the condition was permitted to run a course devoid of even primitive medication. A long experience and contact with the disorder would cause them to view the whole process from such a fatalistic standpoint. Many old people who have lost the major portion of their sight years ago, assert that their immediate parents and grandparents were afflicted in a similar manner. At present the best evidence would indicate that trachoma has been present in these people for generations.

"Certain observations might prove of interest.

(a) The familiar character of trachoma. The chief source of infection and the great channel of transmission is through the family. Examination of children coming from various districts in the residential school invariably indicates the families and areas where one can be certain to encounter the disorder in the greatest degree. In such an area one notes either mental lethargy or stupid stoicism in the attitude of the inhabitants toward the disease. They either see or do not see, and many do not recognize any graduation lying between these opposite poles. This may be due possibly to the insidious onset and imperceptible continuity of the process.

(b) "Certain cases tend to be more resistant to treatment where an accompanying scrofulous diathesis exists. Production of scar tissue by various methods of stimulation has a much poorer response than in more healthy individuals.

(c) "Climate and local factors have an important bearing on the incidence and severity of cases. Areas with high altitude where fine alkali dust, frequent dust and sand storms, intense dryness and heat exist, have the highest index. Here also are encountered the most extreme cases. Districts such as Northern Manitoba or Alberta and in the coastal region of British Columbia where there is more abundant rainfall and much green foliage appear to have a much lower incidence. Positive cases have a much more benign character. It is highly improbable that the more exclusive fish diet of the lower areas as opposed to the high meat consumption in the trachoma belts, has any appreciable influence on the condition.

(d) "Certain individuals in 'trachoma' families appear to have an inherent immunity to the disorder. There is little reason to presuppose that they had not been repeatedly infected as no undue precautions have been instituted to protect themselves against others within the same household.

(e) "Some cases become quiescent with the history of total absence of treatment. The lid condition shows no signs of any activity and casual examination of the pannus shows a relative anæmia. The blood vessels in the area are noted with the 8 magnification glass. How treacherous is this condition, only observation and time will tell. Such cases are classified as 'arrested.'

(f) "Trachoma does not run a steadily progressive

and destructive course. Periods of exacerbations are interpolated between those of the dormancy of subchronicity. Many cases of natural 'arrest' may prove to be only manifestations of a dormant state. Limited observations to date would appear to confirm this.

"In conclusion it may be stated that every effort is being expended compatible with available finances, to bring the situation under control. Dr. E. L. Stone, Director of Medical Service of the Department of Indian Affairs, is to be commended for instituting the campaign which it is hoped will ultimately eradicate trachoma in the Indians of Canada. In this connection, it is most important to keep enthusiasm alive and be prepared to be undeterred by apparent regressions in certain areas. The characteristic chronicity of the disorder will only be overcome by persistent effort. Education of the rising generation with subsequent co-operation on their part will undoubtedly prove the most potent factor in the solution of the trachoma problem in their people."

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COMMUNICABLE DISEASES REPORTED

Urban and Rural : January, 1935

Occurring in the Municipalities of:

Measles: Total 1556—Brandon 630, Unorganized 267, Portage Rural 106, Saskatchewan 57, Winnipeg 46, Lawrence 44, Louise 35, Whitewater 29, St. Clements 28, Elton 25, Whitehead 24, Woodworth 23, Portage City 22, Dauphin Town 22, Winnipegosis 16, The Pas 16, Hamiota Rural 15, Gilbert Plains Rural 14, Bifrost 13, Cornwallis 11, St. Boniface 11, Rivers Town 10, Gretna 8, Hartney 8, Dauphin Rural 7, Virden 7, Harrison 4, Norfolk North 4, Piney 4, Souris 4, Wawanesa 4, Whitemouth 4, Victoria 3, Albert 2, Carman 2, Hamiota Village 2, Langford 2, Miniota 2, Oakland 2, Pilot Mound 2, Swan River Rural 2, St. James 2, Argyle 1, Arthur 1, Daly 1, Dufferin 1, Ethelbert 1, Flin Flon 1, Kildonan East 1, Lorne 1, Minnedosa 1, Neepawa 1, Rhineland 1, Riverside 1, Rockwood 1, Selkirk 1, St. Vital 1, Wallace 1, Woodlands 1.

Chickenpox: Total 241—Winnipeg 194, Unorganized 16, Whitewater 12, St. James 6, Selkirk 3, Oak Lake Town 3, St. Vital 2, Brandon 1, Dauphin Town 1, Kildonan East 1, Rockwood 1, St. Boniface 1.

Scarlet Fever: Total 88—Winnipeg 47, St. Boniface 5, Selkirk 4, St. Vital 4, Kildonan West 3, Stonewall 3, St. James 3, Brandon 2, Coldwell 2, Kildonan East 2, Minto 2, Montcalm 2, Rockwood 2, Rossburn Rural 2, Cameron 1, Hartney 1, Morris Rural 1, Strathclair 1, Unorganized 1.

Mumps: Total 95—Winnipeg 83, St. Vital 10, Dauphin Rural 1, Dauphin Town 1.

Whooping Cough: Total 83—Winnipeg 29, Unorganized 29, Brandon 9, Kildonan West 6, Portage Rural 4, Cornwallis 2, Arthur 1, La Broquerie 1, Rivers Town 1, Transcona 1.

Diphtheria: Total 36—Winnipeg 20, Morris Rural 5, Rhineland 4, Hanover 2, St. Vital 2, Edward 1, Franklin 1, St. James 1.

Tuberculosis: Total 23—Winnipeg 9, Brandon 2, Daly 2, Archie 1, Glenwood 1, Grey 1, Kildonan West 1, McCreary 1, Morden 1, Stanley 1, St. Boniface 1, St. Laurent 1, Wawanesa 1.

Typhoid Fever: Total 15—St. Laurent 11, Unorganized 2, Cameron 1, Hanover 1.

Erysipelas: Total 9—Winnipeg 8, St. James 1.

Diphtheria Carriers: Total 7—Winnipeg 7.

Influenza: Total 4—Winnipeg 3, St. James 1.

Puerperal Fever: Total 1—Winnipeg 1.

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DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of November, 1934.

URBAN—Cancer 41, Pneumonia (all forms) 9, Tuberculosis 8, Puerperal 5, Typhoid Fever 1, Diphtheria 1, Syphilis 1, all others under one year 7, all other causes 126, Stillbirths 17. Total 216.

RURAL—Cancer 26, Pneumonia (all forms) 18, Tuberculosis 13, Puerperal 3, Diphtheria 1, Typhoid Fever 1, all others under one year 7, all other causes 140, Stillbirths 18. Total 227.

INDIANS—Pneumonia (all forms) 5, Puerperal 2, Measles 1, Tuberculosis 1, Whooping Cough 1, all others under one year 1, all other causes 11, Stillbirths 1. Total 23.

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"The Practitioner"—February, 1935.

This number contains a symposium on Rheumatic Diseases in which are the following articles:

"The Diagnosis of Chronic Rheumatic Conditions"—by Sir William Willcox, K.C.I.E., F.R.C.P., Senior Physician, St. Mary's Hospital, London.

"Fibrositis, Lumbago and Sciatica"—by Charles W. Buckley, M.D., F.R.C.P., Hon. Physician, Devonshire Royal Hospital for Rheumatic Diseases.

"Institutional Methods in the Treatment of Chronic Rheumatism"—by Matthew B. Ray, F.R.C.P., Senior Physician, The British Red Cross Clinic for Rheumatism.

"The Spa Treatment of Chronic Rheumatic Conditions"—by Geoffrey Holmes, Senior Physician, Royal Bath Hospital, Harrogate.

"Chronic Rheumatic and Rheumatoid Conditions in Children"—by E. C. Warner, M.D., M.R.C.P., Physician, Children's Department, Miller General Hospital.

Further articles in this number are:

"Latent Sepsis and Its Manifestations"—by W. H. Ogilvie, D.M., M.Ch., F.R.C.S., Surgeon, Guy's Hospital.

"The Diagnosis and Treatment of Acute Pericardial Disease"—by K. Shirley Smith, M.D., B.Sc., F.R.C.P.

"Hyperpiesia"—by G. E. Frederick Sutton, M.R.C.P., Assistant Physician, Bristol Royal Infirmary.

"Salpingitis and Its Treatment"—by John Alexander Mackenzie.

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"The Canadian Medical Association Journal" —February, 1935.

"Dislocation of the Radio-Carpal Joint" — by Frederick J. Tees, B.A., M.D., F.R.C.S. (C.), Assoc. Surgeon, Montreal General Hospital.

—Seven cases of this rare condition are reported. It is pointed out that, until a century ago, radio-carpal dislocation was considered to be the usual result of a fall on the outstretched hand, rather than a fracture of the lower end of the radius.

"Polycythemia Vera, with Special Reference to the Nervous Manifestations." An Analysis of Nine Cases. From the Medical Services of the Montreal General Hospital—by Leyland J. Adams, M.D., C.M., Montreal.

"Complications and Disappointments in Radium Therapy for Cancer of the Uterus"—by Palmer Findley, Omaha, Nebraska.

—Read at the fifty-fourth annual meeting of the Ontario Medical Association, Toronto, May 31st, 1934.

"The Significance of the Post-Operative Thyroid Reaction"—by J. K. Latchford, B.A., M.D., Toronto.

"Retroperitoneal Abscess with Discussion of a Case"—by Charles B. Rich, M.R.C.S., L.R.C.P., Provost, Alberta.

—An excellent case report is given with a discussion of the condition.

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Guy's Hospital Reports—October, 1934.

"Visceral Neuroses" — by John A. Ryle, M.D., Physician to Guy's Hospital.

—A good article describing the various manifestations and treatment of these conditions.

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"The New England Journal of Medicine" —January 17th, 1935.

"Vaginal Hysterectomy" — by Oliver N. Eastman, M.D., Associate Professor of Obstetrics, University of Vermont.

"Gynæcological Problems of Interest to the Surgeon in General Practice" — by Arthur H. Morse, M.D., Professor of Obstetrics and Gynæcology, Yale School of Medicine.

"What is Wrong with the Patient Who Feels Tired, Weak and Toxic?" — by Walter C. Alvarez, M.D., Professor of Medicine, Mayo Foundation.

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"The New England Journal of Medicine" —January 31st, 1935.

"The Association of Pylephlebitis and Appendicitis"—by William H. Snyder, M.D., Marshall G. Hall, M.D., and Arthur W. Allen, M.D. From the Surgical and Pathological Departments of the Massachusetts General Hospital.

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"The Lancet"—January 26th, 1935.

"Postural Hypotension"—by W. F. Croll, M.D., R. J. Duthie, M.D., and J. A. MacWilliam, M.D., Aberdeen.

—A case exhibiting marked variations in blood pressure with change of posture is described — a pronounced fall in pressure accompanied by giddiness invariably taking place in changing from the supine to the standing position.

"Notes on Prostatic and Gastric Uræmia" — by John A. Ryle, M.D., F.R.C.P., London.

—The two conditions are described and appropriate treatment outlined.

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"The Lancet"—January 19th, 1935.

"Treatment of Malignant Disease in the Upper Jaw" — by W. Douglas Harmer, F.R.C.S. (Eng.), Consulting Surgeon to the Throat Department, St. Bartholomew's Hospital.

—The treatment for the various types of malignancy is described and results obtained.

"Renal Dwarfism Associated with Valvular Obstruction of the Posterior Urethra"—by R. W. B. Ellis, M.D., M.R.C.P., London.

"The Clinical Journal"—February, 1935.

"Ascites: Its Diagnostic Significance and Treatment"—by Robert Hutchison, M.D., F.R.C.P.

"The Nature and Relief of Some Common Gastric Symptoms"—by J. A. Ryle, M.D., F.R.C.P.

"Sterility in Women"—by A. C. Palmer, F.R.C.S., Gynæcological Obstetrical Surgeon, King's College Hospital
—A Classification of Sterility is given and the chief causes discussed.

"Deformities of the Toes"—by C. Lambrinudi, F.R.C.S., Orthopædic Surgeon, Guy's Hospital.
—A well illustrated article.

"The Diagnosis and Treatment of Sciatica"—by J. B. Burt, M.D.

"The Diagnosis of Renal and Vesical Disease in General Practice"—by Henry Wade, C.M.G., D.S.O., M.D., F.R.C.S. (Edin.).
—A good article dealing with the various ailments of the Urinary Tract.

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"The Journal of The American Medical Association" February 9th, 1935.

"Early Cutaneous Carcinoma"—by Richard L. Sutton, Jr., M.D., Kansas City, Mo.
—A paper given at the annual meeting of the American Medical Association, June, 1934. It is well illustrated by mico-photographs.

"Therapeutics of the Intravenous Drip: Further Observations"—by Harold Thomas Hyman, M.D., and Arthur S. W. Touroff, M.D., New York.
—Indications, Methods of use and results are given. Numerous photographs illustrate the apparatus and use of same.

To the Members of the Medical Profession of Manitoba

The Manitoba Medical Association, which is a voluntary organization, has since its inception been the only body which could represent the considered opinion of the medical profession of Manitoba to the public, the various governments and other organizations. In this respect its purpose differs from that of the College of Physicians and Surgeons of Manitoba, which is primarily a licensing and disciplinary body, and of the Faculty of Medicine, which is concerned with undergraduate teaching and research.

During the past few years, more than at any time in its history, the Manitoba Medical Association, as the only available organization for this work, has been repeatedly called upon to negotiate with governments and other public bodies in the interests of the members of the medical profession and the public. It is obvious that any equitable arrangements that have been arrived at with other social groups have been an advantage to all medical practitioners whether they are members of the Association or not.

We therefore urge all members of the medical profession in Manitoba, who have not yet joined the Manitoba Medical Association, to do so without further delay. All registered medical practitioners in the province are eligible for membership.

(Signed) G. W. ROGERS, M.D., Dauphin,
President,
Manitoba Medical Association.

News --- Notes --- Correspondence

Joint Meeting of the American and Canadian Medical Association at Atlantic City June 10-14, 1935

The Canadian plans for the conjoint meeting are developing satisfactorily. The Council of the Association will convene in Haddon Hall Hotel on Monday and Tuesday, June 10 and 11. At the Monday luncheon Dr. J. S. McEachern, our President, will present his valedictory address and install his successor, Dr. J. C. Meakins of Montreal. It is expected that officers and members of the Board of Trustees of the American Medical Association will be guests at this function.

On Tuesday evening the installation ceremonies of the joint convention will be held in the Auditorium, at which addresses will be given by Dr. James S. McLester of Birmingham, Ala., and Dr. J. C. Meakins of Montreal, Presidents-Elect of the American Medical Association and the Canadian Medical Association respectively.

General Sessions will be held on Monday and Tuesday, in which four representatives of Canada will take part. They are as follows:

WILLIAM BOYD, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lond.), F.R.S.C., Professor of Pathology, University of Manitoba, Winnipeg.
Subject: "Growth, Normal and Abnormal."

ROSCOE R. GRAHAM, M.B., F.R.C.S. (C.), Assistant Professor of Surgery, University of Toronto.
Subject: "The Surgical Contribution to the Therapy of Duodenal Ulcer."

A. H. GORDON, M.D., C.M., F.R.C.P. (C.), Associate Professor of Medicine, McGill University, Montreal.
Subject: "Bone Changes in Certain Medical Diseases."

H. B. ATLEE, M.D., C.M., F.R.C.S. (Edin.), F.R.C.S. (C.), Professor of Obstetrics and Gynaecology, Dalhousie University, Halifax.
Subject: "Arguments in Favour of a More Active Puerperium Based on a Study of 600 Cases."

During the remainder of the week the convention will be divided up into eighteen sections, officered by representatives from both Associations. The Canadian officers are as follows:

President—DR. J. S. MCEACHERN, Calgary.
President-Elect—DR. J. C. MEAKINS, Montreal.
General Secretary—DR. T. C. ROUTLEY, Toronto.
Chairman of Council—DR. GEO. S. YOUNG, Toronto.
Chairman, Central Programme Committee—DR. A. PRIMROSE, Toronto.

SECTION OF MEDICINE—
Chairman—DR. DUNCAN GRAHAM, 100 College St., Toronto.
Secretary—DR. K. A. MACKENZIE, 89 Spring Garden Road, Halifax.

SECTION OF SURGERY—
Chairman—DR. W. E. GALLIE, Medical Arts Bldg., Toronto.
Secretary—DR. A. R. MUNROE, McLeod Bldg., Edmonton, Alberta.

SECTION OF OBSTETRICS AND GYNAECOLOGY—
Chairman—DR. JOHN FRASER, 1390 Sherbrooke St. W., Montreal.
Secretary—DR. D. C. MALCOLM, 136 Charlotte St., Saint John.

SECTION OF PAEDIATRICS—
Chairman—DR. ALAN BROWN, Medical Arts Bldg., Toronto.
Secretary—DR. HOWARD SPOHN, 825 Granville St., Vancouver.

SECTION OF EAR, NOSE AND THROAT—
Chairman—DR. W. J. MCNALLY, Dept. of Physiology, McGill University, Montreal.
Secretary—DR. W. HACKNEY, Herald Bldg., Calgary.

SECTION OF EYE—
Chairman—DR. W. G. M. BYERS, 1458 Mountain St., Montreal.
Secretary—DR. A. R. CUNNINGHAM, 260 Barrington St., Halifax.

SECTION OF MILITARY MEDICINE—
(Under Section of Miscellaneous Topics)
Chairman—DR. JOHN GUNN, Herald Bldg., Calgary.
Secretary—DR. W. H. DELANEY, 30 Garden St., Quebec.

SECTION OF UROLOGY—
Chairman—DR. D. W. MACKENZIE, Medical Arts Bldg., Montreal.
Secretary—DR. E. R. MYERS, 415 Avenue Bldg., Saskatoon.

SECTION OF RADIOLOGY—
Chairman—DR. W. A. JONES, General Hospital, Kingston, Ontario.
Secretary—DR. H. H. MURPHY, Provincial Royal Jubilee Hospital, Victoria, B.C.

SECTION OF ANAESTHESIA—
(Under Section of Miscellaneous Topics)
Chairman—DR. WESLEY BOURNE, McGill University, Montreal.
Secretary—DR. W. L. MUIR, 240 Jubilee Road, Halifax.

SECTION OF PUBLIC HEALTH AND INDUSTRIAL MEDICINE—
Chairman—HON. DR. W. J. P. MACMILLAN, Charlottetown, P.E.I.
Secretary—DR. A. GRANT FLEMING, McGill University, Montreal.

SECTION OF HISTORICAL MEDICINE—
(Under Section of Miscellaneous Topics)

Chairman—DR. W. W. FRANCIS, McGill University, Montreal.

Secretary—DR. H. E. MACDERMOT, Medical Arts Bldg., Montreal.

SECTION OF PHARMACOLOGY AND THERAPEUTICS—

Chairman—DR. V. E. HENDERSON, Medical Bldg., University of Toronto, Toronto.

Secretary—DR. G. F. STRONG, Medical-Dental Bldg., Vancouver.

SECTION OF PATHOLOGY AND PHYSIOLOGY—

Chairman—DR. WM. BOYD, Manitoba Medical College, Winnipeg.

Secretary—DR. C. H. BEST, Dept. of Physiology, University of Toronto, Toronto.

SECTION OF NERVOUS AND MENTAL DISEASES—

Chairman—DR. A. T. MATHERS, Medical Arts Bldg., Winnipeg.

Secretary—DR. W. V. CONE, 687 Pine Avenue W., Montreal.

SECTION OF DERMATOLOGY AND SYPHILOLOGY—

Chairman—DR. J. F. BURGESS, 1414 Drummond St., Montreal.

Secretary—DR. PAUL POIRIER, 2073 St. Denis St., Montreal.

SECTION OF ORTHOPEDIC SURGERY—

Chairman—DR. R. I. HARRIS, Medical Arts Bldg., Toronto.

Secretary—DR. G. A. RAMSAY, 443 Clarence St., London, Ontario.

SECTION OF GASTRO ENTEROLOGY AND PROCTOLOGY—

Chairman—DR. R. H. M. HARDISTY, Medical Arts Bldg., Montreal.

Secretary—DR. J. K. MCGREGOR, 250 Main St. E., Hamilton.

SECTION OF SCIENTIFIC EXHIBITS—

Chairman—DR. SCLATER LEWIS, 1540 Crescent St., Montreal.

At time of writing, the Canadian contributions to the programme are reported as coming in splendidly and represent the profession from coast to coast.

Haddon Hall, one of the finest hostelries on the American continent, has been chosen as Canadian Headquarters. The hotel rates are as indicated hereunder, and reservations should be made direct:

European Plan—room and bath—one person, per day, $3.00, $4.00, $6.00, $8.00. Two persons, per day, $5.00, $6.00, $8.00, $10.00.

The daily rate for three meals on the American Plan is $3.00. Single meals on the American Plan are as follows: Breakfast, $1.00; luncheon, $1.50; dinner, $2.00.

Further particulars with regard to any phase of the meeting will be gladly supplied upon inquiry addressed to DR. T. C. ROUTLEY, 184 College Street, Toronto, General Secretary of the Canadian Medical Association.

Dr. D. A. Stewart, in the last week of January, addressed the Trudeau Society of Minnesota at Minneapolis on "The Community Versus Tuberculosis"; the Fellows and Faculty of the Mayo Foundation, Rochester, the medical students of the University of Minnesota on "Fifty Years' Progress in Medicine"; and also the senior classes of the two Rochester Schools of Nursing.

Winnipeg General Hospital

The Board of Trustees of the Winnipeg General Hospital invites applications for appointment of Assistant Orthopædist. Applications are to be in by Thursday, March 21st, 1935.

Foot Function --- News Notes

AUTHORITIES agree that over 70% of our population have some static disturbance of the feet. How are we going to give relief to these ailing feet and proper foot comfort to normal feet? First let us look at the mechanics of the foot. Body weight is normally thrust in a line of gravity through the valves slightly medial to the centre of support. Then it is transmitted to the ground via the outer longitudinal arch and the ball of the foot. That the keystone of this outer arch is the cuboid should be remembered.

Originally we walked on the ground without shoes and thereby secured the maximum amount of support to the outer weight bearing points of the foot. Civilization came along and required us to be jacked up on heels and then the trouble started.

Due to the fact that 80% of shoes made today have either weak shanks of none at all, not enough support is being given to the outer part of the foot in many cases. This allows the cuboid to sag thus producing a static error in the foot and a resultant abnormal foot strain.

This same factor—weak shank or no shank whatever—coupled with the strain on the medical arch which is normally present since a body weight tends to force the medial arch inward, combine to produce pronation at the Yalo-Colcaneal articulation and thus exaggerating the static error.

The general principle of treatment of these conditions consists in correcting the abnormal thrush of the line of gravity on the foot so the body weight falls on the foot in a proper relation.

The Macdonald Shoe Store Limited have long considered this problem and as a result are now selling a shoe with a shank strong enough to support the outer weight bearing components in a correct position. This shank is tested to 600 lbs. pressure.

In addition to supporting the cuboid in its correct position the shoe is so designed and built to support the calcaneus in the region of the sustentaulum tali thus taking care of any pronation which may occur. This is the patented Health Spot construction.

This extra support does not interfere with the blood or nerve supply of the foot nor does it give too much pressure on the inner longitudinal arch.

This shoe is now being made in Canada and represents the latest scientific achievement in corrective foot wear—for which we are agents in Winnipeg.

However, these shoes are of no value if not properly fitted. Realizing the tremendous responsibility the shoe man has to the public, we have acquired and developed one of the finest staffs of shoe fitters in the country with whom your patients may be safely entrusted. —Advt.

OBITUARY

DR. SPURGEON CAMPBELL

The sudden death of Dr. Spurgeon Campbell at his home on February 10th, brought sorrow to the hearts of many, not only in Winnipeg where he had practised for nearly thirty years, but throughout Canada, for he had a positive genius for friendship and made friends everywhere.

Born at Iona, Ontario, on April 15th, 1870, he was educated in public schools, Dutton High School, and began his medical course at Western University, London, but took his final year in Manitoba Medical College, graduating in 1904. A general practitioner of the best type, he acquired a large practice in Winnipeg, which was interrupted by the world conflict.

Prior to the onset of the war, he had become an officer in the 16th Cavalry Field Ambulance, succeeding the command in 1914. In 1915 he proceeded overseas with the 4th Field Ambulance and saw service in France. Returning to England in 1917, he became medical officer to the Fifth Division Artillery, but toward the end of that year he again went to France to command No. 4 Canadian Casualty Clearing Station, succeeding the late Lieut.-Col. S. W. Prowse. This unit, which had been raised by the Manitoba Medical College, saw much service during 1918, and Lieut.-Col. Campbell was awarded the C.M.G. In June, 1918, his only son, Kenneth, a pilot in the Royal Air Force, was shot down in aerial combat, and Col. Campbell, on hearing the news, commandeered an ambulance, rushed to the scene, and rescued the body from the wrecked plane in no-man's land. After the Armistice, he was in charge of a demobilization camp at Le Havre.

On his return to Winnipeg, Dr. Campbell resumed practice, his great geniality and kindness of heart making him extraordinarily popular. He was President of the Winnipeg Medical Society, and for thirteen years served on the Honorary Attending Staff of Winnipeg General Hospital.

Dr. Campbell's first wife and his two boys predeceased him, but he is survived by his second wife, nèe Ethel Ferguson of Port Stanley, two brothers, Dr. Alex. Campbell of Grand Rapids, Michigan, who served in the American Expeditionary Force, and J. P. Campbell of Spokane, Washington, and four sisters. After a funeral service in All Saints Church on February 11th, the body was taken to St. Thomas for burial.

"Spurg" Campbell, as he delighted to be called, was not only the devoted practitioner, but the warm-hearted friend, and those who were privileged to know him are the poorer for his passing. Had he chosen to write his epitaph, it might have been in the words of Abon ben Adhem, "Write me as one who lives his fellow men."

DR. CYRIL H. BURGER

Dr. Cyril H. Burger, 926 Warsaw Avenue, Winnipeg, died on February 27th in the Winnipeg General Hospital, after a prolonged illness. He was sixty-six years of age. Dr. Burger was a graduate of Queen's University, and took a postgraduate course in Edinburgh, where he practised for several years. His early life was spent in Kingston, Jamaica. About thirty years ago, he came to Winnipeg to become one of the first radiologists of the city. Retiring in disposition, he was beloved by his friends for his fine character. He is survived by his widow.

DR. RODERICK McDONALD

Dr. Roderick McDonald died at St. Laurent, Manitoba, on February 19th. He was born at Cornwall, Ontario, January 9th, 1852, and graduated from McGill University in 1873. Four years later, he came to Manitoba as physician to the Stonewall Penitentiary, a position which he held for nine years. Afterward, he practiced between Winnipeg and Portage la Prairie, the Pas, and the district between the lakes.

"Consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints."—*Sir William Osler.*